	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 396021		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/24/2023			
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			6 GARDEN C	STREET ADDRESS, CITY, STATE, ZIP CODE: 6 GARDEN CENTER DRIVE GREENSBURG, PA 15601					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII								
F 0000 F 0640 SS=A	Based on a Medicare/N survey, State Licensure Compliance survey con was determined that Re Care was not in compliance requirements of 42 CF. Requirements for Long 28 PA Code, Common Term Care Licensure F.	e survey, and a Civil mpleted on May 24, edstone Highlands Hiance with the follow R Part 483, Subpart g Term Care Facilities wealth of Pennsylva Regulations.	Rights 2023, it Health ving B, es and the mia Long	F 0640	TITLE:	(X6) DATE:			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 20(021)			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/24/2023		
REDSTON	OVIDER OR SUPPLIER: NE HIGHLANDS HEALTH SE NUMBER: 073202	396021 CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	, CITY, STATE, Z	IIP CODE:	03/24/2023	
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0640 SS=A	Continued from page 1			F 0640			
	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must capable of transmitting to the CMS System information each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.		facility neede ncility: htty, s no er a must be ation for inaries, and the days facility		I hereby acknowledge the CI 2567-A, issued to REDSTON HIGHLANDS HEALTH CA for the survey ending 05/24/2 AND attest that all deficience listed on the form will be con a timely manner. This plan of correction is pread executed because it is reby the provisions of the state federal regulations and not be Redstone Highlands Healthce Center agrees with the allegate and citations listed on the state of deficiencies. Redstone Highlands Healthcare Center maintains alleged deficiencies do not, individually and collectively jeopardize the health and safe the residents, nor are they of character as to limit our caparender adequate care as pressed by regulation. This plan of correction shall operate as R. Highlands Healthcare Center written credible allegation of compliance. By submitting this plan of correction, Redstone Highlands	NE ARE CTR 2023, ies rrected in epared quired eand ecause are ations attement ghlands that the ecty of fisuch acity to cribed edstone destrone	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIE IDENTIFICATION NUMB 396021				A (X2) MULTIPLE CONSTRUCTION: A. BLDG:00_ B. WING:			Y
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	RIVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0640 SS=A	Continued from page 2 (ii) Annual assessment. (iii) Significant change in st (iv) Significant correction of (v) Significant correction of (vi) Quarterly review. (vii) A subset of items upon discharge, and death. (viii) Background (face-she transmission of MDS data of an admission assessment. §483.20(f)(4) Data format. the format specified by CM alternate RAI approved by CM This REQUIREMENT is not	of prior full assessment. Figure 1 prior quarterly assessment a resident's transfer, receit) information, for an information for an information resident that does not The facility must transfer S or, for a State which he CMS, in the format specimes.	entry, nitial have nit data in nas an	F 0640	Healthcare Center does not a the accuracy of the deficience This plan of correction is no to establish any standard of c contract, obligation, or posit Redstone Highlands Healthce Center reserves all rights to a possible contentions and def in any civil or criminal clain or proceeding. 1) The minimum data set (M assessment (mandated assess of residents' abilities and car for residents' abilities and car for resident 36 that was due discharge on 3/1/2023 was completed and submitted. 2) A sweep of discharged re was conducted going back 3 to ensure discharge MDS an (Assessment Reference Date for timely completion of the assessments and assessments submitted timely. Identified were corrected at the time of discovery. 3) The Registered Nurse Assessment Coordinator (R) was re-educated on the time	cies. It meant care, ion, and care raise all censes n, action IDS) sments re needs) for the sidents 0 days d ARD e) is set s were issues f	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER. 396021		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 05/24/2023	EY
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN CI GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEED:	F OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	1110 / 111111 111111		(X5) COMPLETE DATE
F 0640	Continued from page 3			F 0640			
SS=A					criteria portion of the Long-Care Facility Resident Asses Instrument (RAI) User's Mar RAI-OBRA (Omnibus Budg Reconciliation Act) required assessment summary. The R will review the "Clinical ME Scheduler" report in electron system daily on business day ensure that all assessments a completed on time. The CMS (Centers for Medicare and M Services) "MDS 3.0 Assessm with Error Number" report wweekly to ensure timely com of the MDS assessments. 4) The Nursing Home Admin or designee will conduct aud ensure that MDS assessment completed on time weekly foweeks then monthly for 2 mc Identified issues are addresse time of discovery. 5) Audit results are reported Quality Assurance Performa Improvement committee to i trends and further opportunit quality improvement and necadditional education.	sment nual, eet NAC OS cic es to re S Iedicaid ments vill be run apletion mistrator its to s are or 4 onths. ed at to the nce dentify cies for	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER 396021				PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 05/24/2023	EY			
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, CITY, STATE, ZIP CODE: 6 GARDEN CENTER DRIVE GREENSBURG, PA 15601						
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE		
F 0640	Continued from page 4		F 0640						
SS=A	Based on review of the								
	Instrument Manual and		· ·						
	well as staff interviews facility failed to compl								
	Data Set (MDS) assess								
	electronic system, the	•							
	and Evaluation System	• • •							
	Submission and Proces								
	the required time frame								
	reviewed (Resident 36)								
	Findings include:	,							
	The Long-Term Care I	Facility Resident Ass	sessment						
	Instrument (RAI) User								
	instructions and guidel	ines for completing	Minimum						
	Data Set (MDS) assess	sments (mandated							
	assessments of a reside	ent's abilities and car	e needs),						
	dated October 2019, in	dicated that Entry, I	Death in						
	Facility, and Discharge	e tracking records m	ust be						
	completed and transmi	tted within 14 days	of the						
	Event Date (Section A	1600 plus 14 days fo	or Entry						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING:		05/24/2023	
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	AIVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0640	Continued from page 5			F 0640			
SS=A	records, Section A2000 Facility records, and Section Discharge records) A nurse's note for Resi 2023, revealed that the home from the facility. Review of the clinical revealed that a discharge completed as of May 2. Interview with the Clir 14, 2023, at 3:31 p.m. tracking record for Reswithin the required time 28 Pa. Code 211.5(f) Compared to the control of the control of the clirical revealed that a discharge completed as of May 2.	dent 36, dated Marc resident was dischauserecord for Resident 36, dated Marc record for Resident 36, dated 4, 2023. Mical Health Navigate confirmed that the disident 36 was not confirmed.	4 days h 1, rged to 36 as not or on May ischarge				
F 0641				F 0641			
SS=D							

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	IDENTIFICATION NUMBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021			<u>w</u>	05/24/2023	
REDSTON	OVIDER OR SUPPLIER: NE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS 6 GARDEN C	CENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 6	ntinued from page 6					
SS=D	483.20(g) Accuracy of Associated Section 1483.20(g) Accuracy of Associated	sessments. Ately reflect the resident	S		1) A Minimum Data Set (MI assessment correction for sec C0100 and section D were use be submitted for residents 15 because those assessments we completed. A new quarterly assessment will be complete residents 15 and 21 including completion of sections C010 section D. A Minimum Data assessment correction for sec N0410G was submitted for resident 44. A Minimum Data Set assecorrection for section H0100 submitted for resident 44. A Minimum Data Set assessment correction for section M0300 submitted for resident 63. A Minimum Data Set assessment correction for section A2100 submitted for resident 66. A Minimum Data Set assessment correction for section B0300 submitted for resident 75. 2) The Registered Nurse Assessment Coordinator will most recent Minimum Data Set assessment Coordinator	ction nable to 5 and 21 vere not d on g 00 and eset etion resident resessment 0D was ent 0 was ent 0 was ent 1 audit Set ents to	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021			<u></u>	05/24/2023	
REDSTON	VIDER OR SUPPLIER: TE HIGHLANDS HEALTH TE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLIANCE OF TH		OULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 7			F 0641			
SS=D					M0300G2 and B0300, H010 A2100. Concerns will be conupon discovery. 3) The Director of Risk Man will re-educate the Registere Assessment Coordinator con Minimum Data Set sections D, N0410G, M0300G2 and Baccuracy. 4) The Clinical Consultant was conduct a random audit of fi Minimum Data Set assessment validate Sections C0100, D, M0300G2 and B0300 accurate weekly x 4 weeks and then real months to ensure accuracy Identified issues will be corrupon discovery. 5) Audit results will be reported the Quality Assurance Performs Improvement committee to it trends and further opportunity quality improvement and neadditional education.	rrected ragement ad Nurse recrning C0100, B0300 vill ve ents to N0410G, acy monthly x rected rected reted to rmance identify ties for	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING:		05/24/2023		
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE	1		
(X4) ID PREFIX TAG	MUST BE PRECEED!	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0641	Continued from page 8		F 0641					
SS=D								
	Based on a review of the Resident Assessment							
	Instrument User's Manual and clinical records, a well as staff interviews, it was determined that t							
	facility failed to compl							
	Set assessments for sev							
	(Residents 15, 21, 22,	44, 63, 66, 75).						
	Findings include:							
	The Long-Term Care I							
	Instrument (RAI) User	-						
	guidance and instruction Minimum Data Set (M	•						
	assessments of a reside	,						
	dated October 2019, re	evealed that the nurse	e was					
	expected to listen to th	, 1	3					
	caregivers about the re medical record, and de	1 ,						
	resident's speech. Sect							
	was to be coded with a	` *	• /					
	one (1) for unclear spe							
	speech. Section B0700	0 (Makes Self Under	rstood)					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING:		05/24/2023	
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 9	Continued from page 9					
SS=D	was to be coded zero (understood, one (1) if tunderstood, two (2) if understood, and three (rarely/never understood coded as rarely/never understood completed any of the reinterviews were conduperiod and should be fathe residents' ability to understood during the period. Section B0800 Others) was to be code understands others, one understands others, two sometimes understands resident rarely/never understands others, two sometimes understands resident rarely/never understands others, two sometimes understands o	the resident was usual the resident was some (3) if the resident was d. The section was a understood if the resident interviews, a cted during the lookactored in when determake himself/herse entire 7-day look-bad (Ability to Understated zero (0) if the resident was of (2) if the resident was others, and three (3) inderstands others. So Interview for Mental be coded zero (0) Nover understood or on articipate in the interview Pain Assessment In	ally netimes s not to be ident s the back ermining If ck and ident isually i) if the fection al Status o if the e (1) Yes view. terview				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 396021		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS. 6 GARDEN C GREENSBUR	ENTER DR	IVE	,	
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 10		F 0641				
SS=D							
55 B	resident was rarely/nev	er understood and o	ne (1)				
	Yes if the resident inte	rview should be atte	mpted.				
	Section D0100 (Should Resident Mood In		erview				
	be Conducted) was to	be coded (0) No (res	ident is				
	rarely/never understoo	d) or (1) Yes (contin	ue with				
	interview).						
	A quarterly Minimum Data Set (MDS) assortion (mandated assessments of a resident's ability care needs) for Resident 15, dated April 1, revealed that Section B0700 (Makes Self Understood) was coded with (2), indicating resident was sometimes able to be understood others and Section B0800 (Ability to Understood) was coded two (2), indicating that a sometimes understood. However, Section was coded with a dash (-), indicating that the status interview was not attempted/assessed Section D (Mood) was coded with a dash (-) indicating that the mood interview was not attempted/assessed.		ties and 2023, g that the bod by rstand she C0100 he mental d and -),				
	A quarterly MDS asses	ssment for Resident	21,				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	XI) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021		A. BLDG: _ B. WING: _		05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0641	Continued from page 11		F 0641				
SS=D	dated March 11, 2023, B0700 (Makes Self Ur (2), indicating that the to be understood by oth (Ability to Understand indicating that she som However, Section C01 (-), indicating that the not attempted/assessed coded with a dash (-), interview was not atternant An interview with the 24, 2023 at 2:29 p.m. r and 21's MDS were consections C and D should the Coded with the intense coded with the numerical received a diuretic pill body get rid of extra flowers.	nderstood) was coded resident was sometimers and Section B08 Others) was coded to tetimes understood. On was coded with a mental status intervitor and Section D (Modindicating that the mapted/assessed. Clinical Consultant devealed that Resider ded incorrectly and the ded incorrectly and the desired bear of days the residual (a medication used to the some the section NO410C ber of days the residual (a medication used to the some the section NO410C ber of days the residual cannot be section to the section used to the sect	d with mes able 800 two (2), dash ew was od) was lood on May hts 15 that eted.				

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		(XI) PROVIDER/SUPPLIER/OIDENTIFICATION NUMBER	I ' '		IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
	, ,	20,004		A. BLDG: _ B WING:	00	05/24/2023	
		396021				03/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	6 GARDEN C GREENSBUR	ENTER DR	RIVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0641	Continued from page 12			F 0641			
SS=D							
	Physician's orders for I	Resident 22, dated A	pril 27,				
	2021, included an orde	er for the resident to	receive				
	hydrochlorothiazide (a	diuretic) every day	for edema				
	(swelling). The residen						
	Record (MAR) for Ma						
	resident received hydro						
	during the seven-day lo	-					
	a quarterly MDS assess		*				
	March 16, 2023, reveal						
	was coded zero (0), inc	-					
	not receive a diuretic d	uring the last seven	days.				
	An interview with the	Clinical Consultant	on May				
	24, 2023 at 2:29 p.m. c		-				
	MDS was coded incorr	rectly and should ha	ve				
	reflected that the reside	ent was receiving a c	diuretic.				
	The RAI User's Manua	al, dated October 20	19,				
	indicated that the inten	·	•				
	(Appliances) was to be		nber of				
	days the resident used						
		* *					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING: _		05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202		CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ID BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0641 Co	ontinued from page 13			F 0641			
Pl 6, pe ev M str se M 20 ca re da A	bileting, such as an incatheter, ostomy, or intenserting a tube directly rine). hysician's orders for Fordan a straight catheter at the very shift for urinary in the target of the very shift for urinary in the target catheter at the target of target of the target of target of the target of targ	Resident 44, dated Description (cath) on retention. The Resident 3, indicated that the at least once a shift eriod. However, a question H0100D (interested (0), indicating the teath himself at least once as the cath himself at least on firmed that Residuently and should have raight cathed at least once as the cathed at least once as th	december to himself dent's resident during the quarterly pril 20, mittent hat the st once a on May lent 44's ve t once				

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/ PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER		:		IPLE CONSTRUCTION:	CION: (X3) DATE SURVEY COMPLETED:		
	, ,				_00	05/24/2022	
		396021		B. WING		05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	6 GARDEN C GREENSBUR	ENTER DR	RIVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 14			F 0641			
SS=D	did not.						
	The RAI User's Manual, dated October 2019,						
	revealed that Section M						
	with the number of uns		-				
	related to a deep tissue	3 (1	•				
	maroon discolored inta underlying soft tissue).						
	coded with a number, t						
	unstageable injuries pro						
	was to be coded in sect	tion M0300G2.	-				
	A quarterly MDS asses	ssment for Resident	63,				
	dated May 5, 2023, rev						
	M0300G1 was marked						
	resident had one unstag						
	to a deep tissue injury.						
	marked "0" to indicate was not present upon a	•					
	However, a nursing no						
	revealed that the reside	•	•				
	emergency medical ser		-				
		•					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING: _		05/24/2023		
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH IE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE		
F 0641	Continued from page 15			F 0641				
SS=D	was noted to have a de heel measuring 2.5 centroller in the Direct 2023, at 1:30 p.m. controller in M0300G2 of Resident assessment, dated May incorrectly. The RAI user's manual revealed that Section A (1) through (8) depend resident's discharge. If to the community (inclusive assisted living facility) was to be coded one (1) discharged to an acute A2100 was to be coded. A discharge note for R 2023, revealed that the an independent living its second controller in the	ector of Nursing on Infirmed that Section 63's quarterly MDS 5, 2023, was coded and the section 63's quarterly MDS 6, 2023, was coded and the section 63's quarterly MDS 6, 2023, was coded and the section of the resident was distuding a boarding ho or home, then Section 1, and if the resident care hospital, then Section 1, and if the resident care hospital, then Section 1, and if the resident care hospital, then Section 1, and if the resident care hospital, then Section 1, and if the resident care hospital, then Section 1, and if the resident 66, dated Appresident was discharged as the section 1, and if the resident 66, dated Appresident was discharged as the section 1, and if the resident 66, dated Appresident was discharged as the section 1, and if the resident w	9, ed one of the scharged me or on A2100 was ection					

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PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396021		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/24/2023	
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0641 SS=D	A discharge MDS assed dated April 18, 2023, rowas coded three (3), in discharged to an acute. Interview with Director May 24, 2023, at 3:40 A2100 of Resident 66' of April 18, 2023, was have been coded to include discharged to the common The RAI User's Manual completing Minimum (mandated assessments care needs), dated October 18, 2023, was the completing Minimum (mandated assessments care needs), dated October 19, dated October 19, dated October 19, dated October 19, dated Marresident was admitted from the completing A nursing admission so Resident 75, dated Marresident was admitted from the completing Minimum (mandated assessments are sident with ability (Hearing Aid) was to be resident used a hearing the completing admission so Resident 75, dated Marresident was admitted from the completing Minimum (mandated assessments are sident was admitted from the completing Minimum (mandated assessments) and the completing Minimum (mandated assessments) and the completing Minimum (mandated assessments) and the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident was admitted from the completing Minimum (mandated assessments) are sident wa	revealed that Section dicating that the resicure hospital. It of Risk Manageme p.m. confirmed that is discharge MDS assonot accurate and should be accurate and	A2100 ident was ent on Section sessment ould nt was entions for essments ties and that for 000 ff the entities in the for that the	F 0641			

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. ,		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING:		05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0641	Continued from page 17		F 0641				
SS=D	no documentation of hadmission. Review of an admission May 14, 2023, revealed (Hearing Aid) was man A witness statement, defeating aides but had I resident did not have had time the interview took 75 was in her wheelch answered all questions. Interview with the Nur May 25, 2023, at 10:32 B0300 of Resident 75's 14, 2023, was not accurable to determine if the with hearing aids.	ated May 22, 2023, lesident 75 stated sheeft them at home. The earing aides in place a place in her room. The air at bedside, was also appropriately. The earing aides in place a place in her room. The earing aides in place are appropriately. The earing aides in place a place in her room. The earing aides in place are the earing aides in place are the earlier of the earlier and the earlier are the earlier at the earlier are the earlier as the facility was also assessment of the earlier as the facility was also assessment of the earlier as the facility was also assessment of the earlier as the facility was also assessment of the earlier as the facility was also assessment of the earlier as the facility was also assessment of the earlier as the facility was also assessment of the earlier as the facility was also assessment of the earlier as the earli	dated) by the e wore he e at the Resident lert, and tator on t Section f May was not				
	28 Pa. Code 211.5(f) C	Clinical records.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021				05/24/2023		
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN CI GREENSBUR	ENTER DR	IVE			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DEI ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0641	Continued from page 18			F 0641				
SS=D								
F 0655				F 0655				
SS=E								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BLDG: _	PLE CONSTRUCTION: 00	(X3) DATE SURVEY COMPLETED:	
		396021		B. WING: _		05/24/2023	
REDSTON	OVIDER OR SUPPLIER: NE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS 6 GARDEN C GREENSBUI	CENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG PREFIX TAG CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		OULD BE	(X5) COMPLETE DATE
F 0655	Continued from page 19			F 0655			
SS=E	\$483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet profession standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission include the minimum healthcare information necess to properly care for a resident including, but not limite (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehension care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's		ment a e essional ust- mission. ecessary nited to-		1) Residents 77, 78 and 80 meside in the facility. 2) A facility wide sweep was conducted to ensure that oth residents receiving renal diatreatments, those with a diagend stage renal disease (kidrfailure), diabetes (a condition results when the body has a in the way it regulates sugar), hypothyroidism (whe body does not make enough hormones), anxiety, anticoagmedication, insulin, impaire areas, antidepressants, and antianxiety medication have plans to reflect their treatmediagnoses. Identified issues corrected at the time of disconditional incomplexity in the medical records. Identified is medical records.	s er lysis gnosis of ney n that problem en the thyroid gulant d skin e care nts and were overy. vided care umented	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023
	admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:				issues were corrected at the discovery. 3) Nursing staff and The Renurse Assessment Coordina (RNAC) were re-educated oneed to have baseline care p	gistered tor n the	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021			00	05/24/2023	
REDSTON STATE LICENS (X4) ID PREFIX	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O		ENTER DR	RIVE		(X5) COMPLETE
TAG	IDENTI	FYING INFORMATION)			CROSS-REFERENCED TO THE A	APPROPRIATE	DATE
F 0655 SS=E	(i) The initial goals of the r (ii) A summary of the residinstructions. (iii) Any services and treatifacility and personnel acting (iv) Any updated informatic comprehensive care plan, as This REQUIREMENT is no	ments to be administered g on behalf of the facility on based on the details of a necessary.	d by the	F 0655	completed with documented evidence that a copy was proto the resident and or their representative. New staff and agency staff will also receive education. The need to devel baseline care plan has been at the admission check list (a cl to ensure that items needed a of the admission are completed). The Director of Nursing of designee will audit the care pure 5 admissions to ensure composite baseline care plan were weeks then monthly x 2 more ensure accurate completion of baseline care plan and docume vidence that a copy was proto the resident and/or designe 5). Audit results will be reported the Quality Assurance Performs Improvement committee to it trends and further opportunity quality improvement and needed additional education.	d new e this lop a added to heck list as a part ted). or blans of bletion ekly x 4 aths to of the mented ovided ee. rted to rmance dentify ties for	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 196021			(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 05/24/2023	EY	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (FACH D			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC' MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0655	Continued from page 21			F 0655			
SS=E							
	Based on review of policies and clinical records, as						
	well as staff interviews	s, it was determined	that the				
	facility failed to ensure that a baseline care plan was						
	developed and implemented, and that a written						
	summary of the baselin						
	the resident and/or the	•					
	three of 41 residents re 80) who were admitted	`					
	80) who were admitted	i on or after May 13,	, 2023.				
	Findings include:						
	The facility's policy re	garding care plans, d	lated				
	March 13, 2023, revea						
	will initiate a baseline						
	facility and complete v		-				
	will include the minim						
	necessary to properly o						
	but not limited to initial orders, physician's order	-					
	orders, social services.	•					
	comprehensive care pla		•				
	care plan if developed	-					
	will provide the resider						
	•	•					

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 396021			PLE CONSTRUCTION: 00	(X3) DATE SURVI COMPLETED: 05/24/2023	EY
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS 6 GARDEN C GREENSBUF	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0655	Continued from page 22			F 0655			
SS=E							
	with a summary of the baseline care plan the		nat				
	includes but is not limit	ited to the initial goa	ls of the				
	resident, a summary of the resident's medi						
	and dietary instruction	•					
	to be administered by t						
	acting on behalf of the		dated				
	information based on t						
	comprehensive care pl	an, as necessary.					
	A diagnosis list for Re	sident 77, dated May	18,				
	2023, revealed that the	resident had a diagr	nosis				
	which included depend	dence on renal dialys	is				
	(mechanical process th	at cleanses the blood	d when				
	the kidneys are not fun	ctioning properly), e	end stage				
	renal disease (kidney f	ailure), and Type I d	iabetes				
	(the pancreas makes lit	ttle or no insulin).					
	Physician's orders for l	Resident 77, dated M	lay 15,				
	2023, included an orde		-				
	Calmoseptine ointmen	t (a skin treatment) t	o the				
	coccyx (tail bone) ever	ry day for impaired s	kin				
	Physician's orders for l	Resident 77, dated M	I ay 18,				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		396021		A. BLDG: _ B. WING: _		05/24/2023		
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	RIVE	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0655	Continued from page 23			F 0655				
SS=E	2023, included an order Humalog (a type of installing given resident's blood sugar I Resident 77, dated Mayorder for the resident to (a type of insulin) once Physician's orders for I 2023, included an order milligrams of Apixaba medication) twice a data A nursing note for Res 2023, indicated that the excoriation noted to the an open area to right be centimeters (cm). A nursing note for Res 2023, indicated that the medication would be a	sulin) per sliding scan depends of the level devel. Physician's of y 18, 2023, included or receive 18 units of e a day. Resident 77, dated May be resident had redness to coccyx and buttook uttooks measuring 0 dident 77, dated May be resident was at diagraph of the resident was at diagraph of the resident part of the resident had redness to coccyx and buttook uttooks measuring 0 dident 77, dated May be resident was at diagraph of the resident was at diagraph.	le (the el of the rders for an el Glargine May 18, receive 5 od thinning 18, ss and ks, with 5 x 0.2					

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		396021		A. BLDG:00_ B. WING:		05/24/2023		
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE		
F 0655	Continued from page 24			F 0655				
SS=E	There was no documer 77's baseline care plan healthcare information for a resident), dated M information about the resident to the use of insulin, die to the buttocks. Interview with the Director 2023, at 1:34 p.m. conscare plan for Resident kidney failure, the use the use of anticoagular and treatment of a skin. A diagnosis list for Resident the which included Type 2 happens because of a pregulates and uses sugare.	(includes the minimal necessary to proper flay 18, 2023, including the sident's care needs alysis, and impaired for the sector of Nursing on Informed there was no 77's dialysis needs referred in the sident for Type I at medication, or for impairment. Sident 78, dated May resident had a diagrated in the way that as a fuel) and anxious and anxious for the sident of the sident in the way that as a fuel) and anxious flat in the sident in the way that as a fuel) and anxious flat is the sident flat in the s	ly care ed related skin areas May 23, baseline elated to diabetes, the care					
	Physician's orders for I 2023, included an orde		-					

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED:	
	396021				00	05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0655	Continued from page 25			F 0655			
SS=E	one 50 milligram (mg) medication to treat dep Physician's orders for I 2023, included an orde Novolog 70/30 (a type (the amount of insulin the resident's blood sugarthere was no document 78's baseline care plan healthcare information for a resident), dated M information about the stothe use of antidepres was no documented evand/or the resident's rewritten summary of the A diagnosis list for Res 2023, revealed that the which included anxiety the thyroid gland does	Resident 78, dated Mor for the resident to of insulin) per sliding given depends of the gar level). Inted evidence that Resident's care needs assant's and insulin, a didence that the residence that the	flay 15, receive ng scale e level of esident num ly care ed related nd there ent d a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
		396021		A. BLDG:00 B. WING:			
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	RIVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0655	Continued from page 26		F 0655				
SS=E	hormones to meet your						
	Physician's orders for I	1ay 18,					
	2023, included an orde						
	30 mg injection of Eno		olood				
	thinner) one time a day	'.					
	Physician's orders for Resident 80, dated May 2023, included an order for the resident to rece one 50 mg tablet of Sertraline (a medication to anxiety) one time a day.						
	Physician's orders for I	Resident 80, dated M	1ay 18,				
	2023, included an orde	r for the resident to	receive				
	one 15 mg tablet of Te treat anxiety) at bedtim		tion to				
	Physician's orders for I 2023, included an orde one 50 microgram (mc medication to treat hyp day.	r for the resident to g) tablet of Synthroi	receive id (a				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING:			
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0655	Continued from page 27			F 0655			
SS=E	There was no documer 80's baseline care plan included information a related to the use of hy (blood thinners), and a there was no document and/or the resident's rewritten summary of the Interview with the Dire on May 23, 2023, at 1: Resident 78's baseline use of antidepressant's 80's baseline care plan hypothyroid, anticoagumedications Interview with the Nur May 24, 2023, at 8:10 was no documented ev 80 and/or their resident received a written sum care plan.	dated May 18, 2022, about the resident's carpothyroid, anticoaguntianxiety medication ted evidence that the presentative received baseline care plan. ector of Healthcare May 18, 2022, and insulin, and that did not include the plants, and antianxiety and confirmed that ridence that Resident ts' responsible partie	are needs ulant ons, and resident d a Navigation hat clude the t Resident use of ty trator on there ts 78 and				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021			<u></u>	05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0655	Continued from page 28			F 0655			
SS=E							
	28 Pa. Code 211.11(e)	Resident care plan.					
F 0656				F 0656			
SS=E							

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/CL PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
					00	05/24/2023	
		396021		B. WING		03/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE D		
F 0656	Continued from page 29			F 0656			
SS=E	483.21(b)(1)(3) Develop/ImPlan §483.21(b) Comprehensive §483.21(b)(1) The facility in comprehensive person-center consistent with the resident and §483.10(c)(3), that inclit timeframes to meet a reside and psychosocial needs that comprehensive assessment. must describe the following (i) The services that are to be maintain the resident's higher and psychosocial well-being §483.25 or §483.40; and (ii) Any services that would §483.24, §483.25 or §483.4 resident's exercise of rights right to refuse treatment und (iii) Any specialized services services the nursing facility PASARR recommendations findings of the PASARR, it resident's medical record. (iv)In consultation with the representative(s)-(A) The resident's goals for outcomes.	Care Plans nust develop and implered care plan for each rights set forth at §483. udes measurable objection's medical, nursing, and are identified in the The comprehensive care for furnished to attain or est practicable physical, gas required under §483. otherwise be required under §483.10, including der §483.10(c)(6). The series of specialized rehability will provide as a result so If a facility disagrees with the series of the ser	ment a esident, 10(c)(2) ves and d mental e plan mental, 3.24, ander ue to the g the tative of with the ale in the	F 0030	1) Resident 12 will have a developed for the care and tr of Type 2 diabetes, hyperten depression, and the use of anticoagulant medications. It is a care plan developed for a Conting Positive Airway Pressure (CPAP-device used to keep breathing airways open whill sleep). Resident 20 will have plan updated to reflect the difference of insulin dependent diabeter. Resident 22 will have their compared to include their preferegarding activities. 2) A sweep was conducted ensure that other residents we diagnoses of Type 2 diabetes insulin dependent diabetes, hypertension, depression, us anticoagulant medications, a using CPAP-devices have care to reflect their use. In additions weep was conducted to ensure that their cativities prefered in the residents have care planeties their activities prefered in the Registered Nurse.	reatment sion, Resident eloped to nuous e you e care agnosis s. eare plan erences d to ith s, ing nd are plans on, a ure ns to ences.	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023
	(B) The resident's preference	e and potential for futur	e		Assessment Coordinator (RN	NAC)	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/24/2023	
REDSTON	OVIDER OR SUPPLIER: NE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OULD BE	(X5) COMPLETE DATE
F 0656 SS=E	discharge. Facilities must d desire to return to the comm referrals to local contact agentities, for this purpose. (C) Discharge plans in the cappropriate, in accordance in paragraph (c) of this sect §483.21(b)(3) The services facility, as outlined by the cities in the cappropriate in paragraph (c) is not service facility. This REQUIREMENT is not service in paragraph (c) is not service facility as outlined by the continuous management in the continuous facility.	nunity was assessed and encies and/or other appro- comprehensive care plan with the requirements section. provided or arranged by comprehensive care plan and trauma-informed.	any opriate a, as t forth	F 0656	and Lifestyles staff were re- on the need to have compred care plans developed accuratimely. The RNAC will run listing report (a report within electronic medical record that new physician orders) on but days to double check that ne orders have been care planned. The Director of Nursing designee will run the order I report and check to ensure n orders and preferences are caplanned on 5 residents week weeks then monthly x 2 more ensure accurate care plan up have occurred. Audit results will be reported in the Quality Assurance Perfo Improvement committee to it trends and further opportunit quality improvement and ne additional education.	nensive tely and the order in the at lists all siness w ed. g or isting ew are lly x 4 inths to dates ported to rmance identify ties for	

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PLAN OF CORRECTION (POC) IDENTIFICATION NUMB		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00_ B. WING:		(X3) DATE SURVI COMPLETED: 05/24/2023	EY
	VIDER OR SUPPLIER: E HIGHLANDS HEALTH	396021 CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	CITY, STATE, Z ENTER DR	MP CODE:	03/24/2023	
STATE LICENSE NUMBER: 073202							
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0656	Continued from page 31		F 0656				
SS=E							
	Based on clinical recor	rd reviews, as well as	s resident				
	and staff interviews, it						
	facility failed to develop comprehensive care plans						
	that included specific and individualized preferer regarding health care needs, oxygen needs,						
	diabetes, and activities						
	reviewed (Residents 12						
	Findings include:						
	An admission Minimum	m Data Set (MDS)					
	assessment (a mandate						
	abilities and care needs						
	April 5, 2023, revealed cognitively intact, requ						
	staff for bed mobility,						
	and hygiene and had d		•				
	fibrillation (rapid heart						
	blood pressure), and T	ype 2 diabetes.					
	Physician's orders for I	Resident 12, dated A	pril 29,				
	2023, included an orde						
	25 milligrams of Sertra	aline (antidepressant					

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	KI) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021		A. BLDG:00_ B. WING:		05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202		CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0656	Continued from page 32			F 0656			
SS=E	medication) once a day for depression. Physician's orders for Resident 12, dated April 29, 2023, included an order for the resident to receive 5 milligrams of Eliquis (anticoagulant medication) twice a day for hypertension. Physician's orders for Resident 12, dated April 29, 2023, included an						
	order for the resident to						
	Furosemide (diuretic n hypertension.	-					
	Physician's orders for Resident 12, dated April 29 2023, included an order for the resident to receive 1000 milligrams of metformin (diabetic medication twice a day for Type 2 diabetes.						
	Physician's orders for Resident 12, dated May 6, 2023, included an order for the resident to receive Lispro (a type of insulin) per sliding scale (the amount of insulin given depends of the level of the resident's blood sugar level).		receive (the				
	Interview with the Dire	ector of Health Care					

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		` '	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021		A. BLDG: _ B. WING: _		05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE	1	
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0656	Continued from page 33		F 0656				
SS=E	Navigator on May 24, confirmed that Resider developed for the care diabetes, hypertension, anticoagulant medicati A quarterly Minimum (a mandated assessmer care needs) for Resider 2023, revealed that the intact, required extensineeds, used supplement that included chronic representation of the Positive Airway Pressukeep breathing airways bedtime and off in the An interview with the 23, 2023, at 10:14 a.m. 23, 2023, there was no	and treatment of Ty, depression, and the ons and should have Data Set (MDS) asset of a resident's abilit 16, dated February resident was cognit ave assistance with datal oxygen, and had espiratory failure. Lesident 16, dated Maresident to use Containe (CPAP-device uses open while you sleemorning. Director of Nursing confirmed that as o	pe 2 use of been. essment ities and y 21, ively aily care diagnosis arch 11, inuous sed to ep) on at on May f May				

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***************************************		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021		A. BLDG:00_ B. WING: 05/24/2023		05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202		CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0656	Continued from page 34		F 0656				
SS=E	regarding Resident 16's use of a CPAP device. A quarterly MDS assessment for Resident 20, dated May 3, 2023, revealed that the resident w cognitively intact and had diagnoses that includ diabetes with insulin dependence. There was no documented evidence that the resident's care play which was initiated on July 15, 2022, included a care plan for diabetes. Interview with the Director of Nursing on May 2023 at 1:32 p.m. confirmed that Resident 20's						
	plan was not individua diabetes, and it should		esident's				
	A quarterly MDS assest dated March 16, 2023, was cognitively intact assistance from staff for	sident					
	An interview with Res. 10:02 a.m. revealed that	ident 22 on May 21,	•				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		396021			00	05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	RIVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0656	Continued from page 35		F 0656				
SS=E	activities to be scheduled, especially on the weekends when there currently are none. There was no documented evidence that the resident's care plan, which was initiated January 24, 2021, included the resident's preferences regarding activities. Interview with the Activities Director on May 24, 2023 at 1:59 p.m. confirmed that Resident 22's care plan was not individualized regarding the resident's preference for activities, and it should have been. 28 Pa. Code 211.11(d) Resident care plan.		There lent's 2021, ng May 24, 22's care resident's				
F 0657				F 0657			
SS=D							

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	MBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021			00	05/24/2023	
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0657	Continued from page 36			F 0657			
SS=D	483.21(b)(2)(i)-(iii) Care Plas 483.21(b) Comprehensive \$483.21(b)(2) A comprehen (i) Developed within 7 days comprehensive assessment. (ii) Prepared by an interdisc is not limited to-(A) The attending physician (B) A registered nurse with (C) A nurse aide with respon (D) A member of food and (E) To the extent practicable resident and the resident's reexplanation must be included if the participation of the resrepresentative is determined development of the resident (F) Other appropriate staff of determined by the resident's resident. (iii)Reviewed and revised by each assessment, including quarterly review assessment.	Care Plans sive care plan must beafter completion of the iplinary team, that inclusive responsibility for the resident nutrition services staff. It is the participation of the presentative(s). And in a resident's medical sident and their resident not practicable for the resident not practicable for the resident or professionals in discipneeds or as requested by the interdisciplinary teach the comprehensive is.	des but sident. e I record blines as y the		1) Resident 16's care plan revised to resolve the urinary infection and antibiotic use. Resident 20's care plan has be revised to resolve the leg wooleg wound infection. 2) A sweep was conducted other resident care plans to e that resolved infections and be impaired skin areas were rest the care plans. 3) The Registered Nurse Assessment Coordinator (RN and intradisciplinary team were-educated on the need to recare plans timely. The RNAC the order listing report (a repwithin the electronic medicathat lists all new physician of on business days to double contained and or revised as applanned and or revised as applanned and or revised as applanned and check to ensure morders are care planned on 5 residents weekly x 4 weeks to monthly x 2 months to ensure accurate care plan updates here	y tract been bund and d of ensure healed olved on NAC) ere evise C will run bort I record rders) heck are plicable. g or isting ew chen	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED:	
		396021				05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C. GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0657	Continued from page 37			F 0657			
SS=D					occurred. 5) Audit results will be repthe Quality Assurance Perform Improvement committee to it trends and further opportunit quality improvement and need additional education.	rmance dentify ties for	
	Prodice of the Production of t		riconde Pe				
F 0658				F 0658			
SS=D							

STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIE IDENTIFICATION NUMB				PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:		
		396021			<u></u>	05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202		H CARE CTR	STREET ADDRESS 6 GARDEN C GREENSBUE	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEI	IT OF DEFICIENCIES (EACH DE DED BY FULL REGULATORY O FIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0658	Continued from page 38			F 0658			
SS=D	483.21(b)(3)(i) Services P Standards §483.21(b)(3) Comprehen The services provided or a outlined by the compreher (i) Meet professional stand. This REQUIREMENT is a	sive Care Plans rranged by the facility, as sive care plan, must- lards of quality.			1) Resident 12 had no adverifects from not having a Re Nurse (RN) assessment of a impaired skin area that was the left heel. Heel has been a by an RN. Resident 15 had radverse effects from not hav Registered Nurse (RN) assess resident when their head was bumped with a mechanical 12. A facility wide sweep we conducted going back 7 days ensure that there was an RN assessment for any changes condition. Concerns will be addressed upon discovery. 3) Licensed nursing staff or re-educated on the need to have Registered Nurse (RN) assess for changes in condition. Ne and new agency staff will also receive the education. The Registered Nurse Supervisor designee will review the 24-report (an electronic summar resident documentation) dail changes of condition and ensured that an RN assessment was competed. Any identified isse	gistered new noted on ussessed no ing a sis the sift. will be sito in will be ave ssments w staff so or hour ry of y for sure	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIE IDENTIFICATION NUMB				A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	396021 CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0658 SS=D	Continued from page 39		A statice A static A sta	F 0658	be addressed at the time of discovery. 4) The Director of Nursing designee will conduct randor of 5 residents via the 24-hou for changes of condition and that an RN assessment was competed weekly for 4 week monthly for 2 months. Identification issues will be addressed at the of discovery. 5) Audit results will be repthe Quality Assurance Perform Improvement committee to it trends and further opportunit quality improvement and negational education.	m audits ar report I ensure as then iffied the time ported to armance identify ties for	

		` '	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING: _		05/24/2023		
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN CI GREENSBUR	ENTER DR	RIVE			
(X4) ID PREFIX TAG	MUST BE PRECEEDI	F OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0677 SS=D	483.24(a)(2) ADL Care Pro §483.24(a)(2) A resident what in good nutrition, growthygiene; This REQUIREMENT is not	ho is unable to carry out eives the necessary serv coming, and personal an	ices to	F 0677	1) Resident 45 had their faremoved. 2) A sweep was conducted ensure other female resident unwanted facial hair were id and residents were assisted to remove their unwanted facial hair were reconstructed in the importance of assisting residents with the removal of unwanted facial hair. New stonew agency staff will also resident task updated to include the removal of unwanted facial hair. 4) Director of Nursing or will round on 10 residents to unwanted facial hair has been removed weekly x 4 weeks to monthly x 2 months. 5) Audit results will be reported the Quality Assurance Perform Improvement committee to it trends and further opportunit quality improvement and new additional education.	d to s with lentified to al hair. ducated ag if taff and eceive as will be val of designee o ensure en then ported to rmance identify ties for	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER 396021			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH C STATE LICENSE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
PREFIX MUST BE PRECEEDED	OF DEFICIENCIES (EACH DEI OF BY FULL REGULATORY OF VING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
Based on clinical record interviews, it was detern to ensure that dependent with the necessary service grooming, by failing to I facial hair for one of 41 (Resident 45). Findings include: An annual Minimum Da mandated assessment of care needs) for Resident revealed that the resident revealed that the resident required extensive assist hygiene, and had diagno atrioventricular block (a disorder). Observations of Resident resident resident sitting in her who will be a service of the service of th	residents were process to maintain persidents were process to maintain persidents reviewed at a Set (MDS) assess a resident's abilitie 45, dated April 27 at was cognitively interact from staff for each that included contract that are the staff of the s	essment (a es and , 2023, mpaired, personal omplete	F 0677			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		396021			00	05/24/2023		
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	RIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE		
F 0677	Continued from page 42			F 0677				
SS=D	with other residents, vi with multiple light-coloquarter of an inch long documentation in the conther resident refused to shaving completed. Of 2023, at 10:08 a.m. reviber wheelchair in the hofacial hair. An interview with Nur 2023, at 12:20 p.m. conpresent on Resident 45 be there. An interview with the 23, 2023, at 1:07 p.m. residents should not had chin for three consecutives and the consecutive should be a	ored hairs, approximation on her chin. There clinical record to indicate have personal hygie between the beservations on May we aled that she was shallway with no notice that she was shallway with no notice that facial had been also been and that it should be confirmed that femantice are noticeable hair of the days.	mately one was no icate that ne or 24, itting in ceable May 23, air was ould not on May le n their					

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
396021 B. WING:					05/24/2023		
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0679				F 0679			
SS=D							
					1		

PLAN OF CORRECTION (POC) IDENTIFICATION NU		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING: _		05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202		CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIEN MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0679	Continued from page 44			F 0679			
SS=D	483.24(c)(1) Activities Mee §483.24(c) Activities. §483.24(c)(1) The facility nomprehensive assessment preferences of each resident support residents in their chacility-sponsored group an independent activities, designed support the physical, movell-being of each resident, independence and interaction. This REQUIREMENT is not support the physical of the physical	nust provide, based on the and care plan and the i, an ongoing program to oice of activities, both d individual activities argued to meet the interest ental, and psychosocial encouraging both on in the community.	ne o		1) Staff reviewed Residen #20; #22; and #48 assessmer ensure activity preferences a met and available to resident 2) Lifestyles Director and/designee will conduct a who sweep of activity assessment review and ensure all in-hou residents' preferences are being addressed in resident's plan of and also aligning with the act department's generated activical calendar. 3) Lifestyles Director and/designee will generate an act calendar with scheduled, org activities on the weekend and evenings. Activity staff will educated by Nursing Home Administrator on activity assessment accuracy with results will be monitor activity calendars to ensure organized and scheduled act are being held on the weekend available during evening how will be done monthly x3. 5) Audit results will be reparted.	nts to are being ts. /or ale-house ts to see ing of care etivity ity /or tivities ganized d /or be sidents. strator r the ivities and and ars. This	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	NUMBER:		IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021		B. WING:			
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH IE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	RIVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0679	Continued from page 45			F 0679			
SS=D				the Quality Assurance Performs Improvement committee to it trends and further opportunit quality improvement and neadditional education.	dentify ties for		
F 0684				F 0684			
SS=D							

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021			<u></u>	05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS. 6 GARDEN C	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 46			F 0684			
SS=D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundame treatment and care provided the comprehensive assessm must ensure that residents re accordance with professions comprehensive person-center residents' choices. This REQUIREMENT is no	I to facility residents. Ba ent of a resident, the fac eceive treatment and car al standards of practice, ered care plan, and the	ised on ility e in		1) Resident 16 had no adveffects from having low blood pressures and having antihypertensive medication medication to lower blood purely held without notifying the rephysician. The physician was updated on condition, vital s and made aware of held dose 2) A facility wide sweep g back 14 days on current inhoresidents will be conducted the ensure that any residents who blood pressure medications is systolic blood pressures less 100 had physician notification belood pressure and/or medications being held. Con will be corrected upon discording the corrected upon discording	(a ressure) sident's s signs es. going ouse to o had held or than on of the herring otify s are d New fill also Director review	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023

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OF DEFICIENCIES AND RECTION (POC)			A. BLDG: _	00	(X3) DATE SURVEY COMPLETED: 05/24/2023	
VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	6 GARDEN C	ENTER DR	IVE		
MUST BE PRECEEDE	D BY FULL REGULATORY OF		ID PREFIX TAG	CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE
Continued from page 47			F 0684	daily for doses of medication were held and ensure that the physician was notified. Any identified issues will be addressed the time of discovery. 4) The Director of Nursing designee will conduct an aud medications held requiring ponotification weekly x 4 week then monthly x 2 months. Con	e that e e e e e e e e e e e e e e e e e e e	
	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202 SUMMARY STATEMENT MUST BE PRECEEDE IDENTII	RECTION (POC) IDENTIFICATION NUMBER: 396021 VIDER OR SUPPLIER: E HIGHLANDS HEALTH CARE CTR E NUMBER: 073202 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)	ASTRECTION (POC) IDENTIFICATION NUMBER: 396021 STREET ADDRESS, 6 GARDEN C GREENSBUR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	A. BLDG: _ B. WING: _ ZIDER OR SUPPLIER: E HIGHLANDS HEALTH CARE CTR E NUMBER: 073202 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IDENTIFICATION NUMBER: A. BLDG: _ B. WING: _ C GREENSBURG, CITY, STATE, Z C GARDEN CENTER DR GREENSBURG, PA 1560 PREFIX TAG	A BLDG:	A. BLDG:00

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	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIE DEAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		396021		A. BLDG:00_ B. WING:			
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 48			F 0684			
SS=D							
	Based on review of clinical records, as well as staff						
	interviews, it was determined that the facility failed						
	to ensure that a physici						
	pressures and medications being held for one of 41						
	residents reviewed (Re	esident 16).					
	Findings include:						
	A quarterly Minimum	Data Set (MDS) ass	essment				
	(a mandated assessmer	nt of a resident's abil	ities and				
	care needs) for Resider	nt 16, dated Februar	y 21,				
	2023, revealed that the	•	-				
	intact, required extensi		•				
	needs, used supplemen		diagnosis				
	that included chronic re	espiratory failure.					
	Physician's orders for I 14, 2023, included for milligrams (mg) of Me high blood pressure) to hypertensive heart dise high blood pressure).	the resident to receive toprolol Tartrate (use to times a day for	ve 25 sed to treat				

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	TATEMENT OF DEFICIENCIES AND LAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLII IDENTIFICATION NUMBER 396021 AME OF PROVIDER OR SUPPLIER: EDSTONE HIGHLANDS HEALTH CARE CTR			(X2) MULTI A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		396021		B. WING:		05/24/2023	
REDSTON		CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE	1	
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 49			F 0684			
SS=D							
	A nurse's note for Resi						
	2023, at 6:51 a.m. reve						
	low blood pressure of 86/50 millimeters of mercur (mm/Hg).						
	Review of the Medicat	tion Administration	Record				
	(MAR) for Resident 10						
	documentation of the f	•	•				
	March 2 on night shift on evening shift was 9						
	shift was 98/62 mm/Hg	-					
	was 98/62 mm/Hg; Ma	_	-				
	91/60 mm/Hg; and Ma	•					
	99/65 mm/Hg. Review	v of the MAR also re	evealed				
	that the resident's meto	-					
	on March 1 at 8:00 a.m	n. and March 5, 6, ar	nd 7 at				
	10:00 p.m.						
	There is no documente	ed evidence in Reside	ent 16's				
	clinical record to indic	ate that the physician	n was				
	notified of the above-n						
	pressures or the Metop	rolol doses that were	e not				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021				05/24/2023	
			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	RIVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0684	Continued from page 50	Continued from page 50					
SS=D	administered.						
	An interview with the Director of Nursing on May 23, 2023, at 10:14 a.m. confirmed that there was no						
	documented evidence that the physician was notific						
	of Resident 16's low bl Metoprolol doses that						
	Metoprolol doses that were not administered. 28 Pa. Code 211.12(d)(1)(5) Nursing services						
F 0688				F 0688			
SS=E							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		396021				05/24/2023		
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH IE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE	
F 0688	Continued from page 51			F 0688				
SS=E	483.25(c)(1)-(3) Increase/Pr ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility in enters the facility without li experience reduction in rang- resident's clinical condition in range of motion is unavo §483.25(c)(2) A resident wi- receives appropriate treatmer range of motion and/or to prof motion. §483.25(c)(3) A resident wi- appropriate services, equipmer improve mobility with the independence unless a reduction of the pro- demonstrably unavoidable. This REQUIREMENT is not	nust ensure that a reside mited range of motion dige of motion unless the demonstrates that a redicidable; and the limited range of motion and services to incresevent further decrease in the limited mobility receivent, and assistance to me maximum practicable ction in mobility is	on ase nrange		1) A rehab screen will be completed for resident 5 to a current range of motion state current restorative or rehab proceeds. A rehab screen will be completed for resident 17 to current functional mobility a restorative or rehab program A rehab screen will be compresident 45 to assess ambula status and restorative or rehap program needs. 2) A sweep will be conduct other residents with care planestorative nursing program. Affected residents will have screen completed to determic current functional status and for restorative or rehab nursi services. 3) A nurse will be designated oversee the restorative program. Affected on resonance the restorative program oversee the restorative program and the need to determine the effectiveness of the program 4) The Director of Nursing designee will conduct an audition of the program will be designed will conduct an audition of the program will be designed will conduct an audition of the program will be designed will conduct an audition of the program will be designed will conduct an audition of the program will be designed will conduct an audition of the program will be designed wil	as and brogram be assess and needs. bleted for tion ab cted of a rehab ne their need fing atted to fam. storative rmine a te and a g or	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023	

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			IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING: _		05/24/2023		
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0688	Continued from page 52			F 0688				
SS=E					resident documentation to er that residents with a restoratinursing program are having documentation completed an re-evaluations to determine a for participation weekly x 4 and then monthly x 2 months. Concerns will be addressed a discovery. 5) Audit results will be repthe Quality Assurance Performs Improvement committee to it trends and further opportunit quality improvement and neadditional education.	ability weeks s. upon corted to rmance dentify ties for		

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING: _		05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS 6 GARDEN C GREENSBUF	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0688	Continued from page 53		F 0688				
SS=E							
	Based on a review of fand staff interviews, it facility failed to ensure nursing to maintain and range of motion for the (Residents 5, 17, 45). Findings include: The facility's policy redated March 13, 2023, receive restorative nursipromote optimal safety. A quarterly Minimum (a mandated assessment care needs) for Resident revealed that the resident required extensive assist personal hygiene, and dementia. Resident 5's care plan,	was determined that the the provision of residents red/or to prevent a decree of 41 residents red revealed that residents and independence. Data Set (MDS) assent of a resident's abiling to 5, dated April 13, ent was cognitively its assistance from sthad diagnosis that in	Nursing, nts will to help essment ities and 2023, mpaired, aff for acluded				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIF IDENTIFICATION NUMBER 1990				PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 05/24/2023	ΞY
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS 6 GARDEN C GREENSBUE	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
F 0688	Continued from page 54	Continued from page 54					
SS=E	indicated that the resid functional ability and s range of motion (AAR strength, endurance an once daily as tolerated included an intervention AAROM to all joints to contracture and maintan ability once daily. There was no document range of motion being and there was no evided of motion had been assuresident was participat program. An annual MDS assess April 26, 2023, indicate cognitively impaired a staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion in the staff for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further transport of motion had been assured to the staff for daily care need dated June 15, 2020, in at risk for decline in further tran	she will perform action OM) to all joints to ad functional ROM and The resident's care on for the resident to o decrease the risk of ain/improve range of the devidence of rest completed for Resident to the resident that the resident is sessed to determine it ing in the restorative of the determine it is a session of the resident of the determine it is a session of the resident of	ve assisted maintain bilities plan receive of motion orative lent 5, l's range of the nursing 7, dated was ce from re plan, dent was				

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTI A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		396021		B. WING:		05/24/2023	
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH IE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0688	Continued from page 55		F 0688				
SS=E	maintain mobility and maximum level of indexidence of increased that as tolerated. The residence with a minimum a wheeled walker. The resident was to walk 150 feet with two return to lying on back feet once seated in wheeled with two turns wheelchair/scooter. There was no document record of restorative properties abilition wheel herself in her determine if the residence restorative nursing properties.	ependence/safety with falls by ambulating of ent's care plan, dated the resident would be saistance of one staff resident's task list indownalk 10 feet every of turns, roll right and on the bed, would welchair/scooter, and once seated in the rograms being provident's task list was not and there was no extry to walk, turn herse that was participating of ent's ambulating and there was participating of the rograms being provident's task list was not and there was no extry to walk, turn herse that was participating of the rograms being provident's task list was not and there was no extry to walk, turn herse that was participating of the rograms being provident's task list was not and there was no extry to walk, turn herse that was participating of the rograms being provident to walk turn herse that was participating the rograms being provident to walk turn herse that was participating the rograms being provident to walk turn herse that was participating the rograms being provident to walk turn herse that was participating the rograms being provident to walk turn herse that was participating the rograms being provident to walk turn herse that was participating the rograms being provident to walk turn herse that was participating the rograms being provident to walk turn herse that was participating the rograms being provident to walk turn herse that was participating the rograms to the rograms to the rogram to walk turn herse that was participating the rogram to the r	chout once daily I June walk 80 If and a dicated shift, left and wheel 150 wheel clinical ded to ot vidence elf in bed, assed to				

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTI A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		396021		B. WING: _		05/24/2023	
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEED!	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0688	Continued from page 56		F 0688				
SS=E	An annual MDS assess April 27, 2023, revealed cognitively impaired, in from staff for personal that included complete of heart rhythm disords. Resident 45's care plant indicated that the reside functional ability and sendurance to achieve in independence/safety with falls by ambulating one resident's care plan into 2021, revealed that the with a minimum assist wheeled walker with a The resident's task list was to be walked 10 fewith two turns. There was no documer record of restorative are	ed that the resident we required extensive as hygiene, and had distartioventricular blocker). In revised May 11, 20 and the will maintain more maximum level of rithout evidence of ince daily as tolerated. The resident would wall ance of one staff and wheelchair following indicated that the reservence every shift, walk anted evidence in the enterty of the control	sistance agnosis ck (a type 023, ecline in bility and nereased The il 22, k 50 feet dang her. sident 150 feet clinical				

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	STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER. PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTI	IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021			00	05/24/2023	
REDSTONE HIGHLANDS HEALTH CARE CTR			STREET ADDRESS, 6 GARDEN C. GREENSBUR	ENTER DR	RIVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0688	Continued from page 57			F 0688			
SS=E	The resident's task list consistently and there resident's ability to wall determine if the resident restorative nursing profile. Interview with the Hear 2023, at 10:00 a.m. con longer had a full restor was no clear way to departicipating in a restor they are unable to particular they are unable to partic	was no evidence that lk had been assessed in the was participating gram. Ith Navigator on Manfirmed that the facilitative program and the termine if a resident rative nursing prograticipate.	ay 24, lity no hat there is				
F 0695 SS=D				F 0695			

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-	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021				05/24/2023	
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0695	Continued from page 58	tinued from page 58		F 0695			
SS=D	483.25(i) Respiratory/Trach § 483.25(i) Respiratory care and tracheal suctioning. The facility must ensure tha respiratory care, including t suctioning, is provided such professional standards of pr person-centered care plan, t preferences, and 483.65 of t This REQUIREMENT is not	e, including tracheostom t a resident who needs racheostomy care and tractice, consistent with actice, the comprehension he residents' goals and his subpart.	y care		1) Residents 16, 20, and 22 physician orders added to interest the use of and cleaning of the Continuous Positive Airway Pressure-CPAP-devices (use keep breathing airways open you sleep). Their care plans also updated to reflect their ucleaning. 2) A sweep was conducted ensure that other residents us CPAP-devices had physician and care plans for their use a cleaning. 3) Licensed nurses were re-educated on the need to haphysician orders and care plans taff and new agency staff were eive this education. CPAP-devices were added to items to be reviewed during clinical meeting to ensure or care plans are in place. 4) The Director of Nursing designee will conduct an aud CPAP-device orders and care weekly x 4 weeks and then in 2 months to ensure completic	clude eir ed to while were use and d to sing n orders and ave ans for ng. New rill also o list of the daily ders and g or dit of e plans nonthly x	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021				05/24/2023		
REDSTON	VIDER OR SUPPLIER: TE HIGHLANDS HEALTH TE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C. GREENSBUR	ENTER DR	RIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
F 0695	Continued from page 59			F 0695				
SS=D	Bood on internal failure dictor de del internal y il sas of of on one			Concerns will be addressed udiscovery. 5) Audit results will be repthe Quality Assurance Perfor Improvement committee to it trends and further opportunit quality improvement and neadditional education.	ported to rmance dentify ties for			
F 0698		(3) Hurshig-Selvices	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	F 0698				
SS=D								

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER. 396021		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202		STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0698	Continued from page 60			F 0698			
SS=D	483.25(1) Dialysis. The facility must ensure tha receive such services, consistandards of practice, the cocare plan, and the residents' This REQUIREMENT is not	stent with professional imprehensive person-cer goals and preferences.			1) Physician orders were of for resident 77 to receive dia treatments and monitoring of access sites. 2) A sweep was conducted ensure other residents received dialysis treatments had physicorders for the treatments and monitoring of access sites. 3) Licensed nurses were re-educated on the need to haphysician orders for dialysis treatments and monitoring of sites. New staff and new age staff will also receive this ed Dialysis treatments were addist of items to be reviewed of the daily clinical meeting to orders are in place for the treand monitoring of the access 4) The Director of Nursing designee will conduct an audialysis orders weekly x 4 we then monthly x 2 months to completion. Concerns will be addressed upon discovery. 5) Audit results will be reptite Quality Assurance Perfol Improvement committee to in	ave f access fuction. ded to during ensure exatments a sites. g or dit of eeks and ensure e ported to rmance	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING: _		05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE		
F 0698	Continued from page 61			F 0698			
SS=D					trends and further opportunit quality improvement and neo additional education.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER 396021			(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVEY COMPLETED: 05/24/2023		
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS 6 GARDEN C GREENSBUE	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0698 SS=D	Continued from page 62 Based on review of po	cords, as	F 0698				
	well as observations and resident and staff interviews, it was determined that the facility failed to obtain physician's orders for dialysis or for the care and monitoring of dialysis sites for one of 41 residents reviewed (Resident 77).						
	Findings include: The facility's policy receive dialysis (mechathe blood when the kid properly), dated Marchhemodialysis procedur responsibility and supedialysis agency.	leanses ning that the e direct					
	The outpatient dialysis August 23, 2013, indic outpatient dialysis faci written protocol governolicies, and procedure dialysis services to res	eated that both the fac- lity would mutually ning specific reponsi- es to be used in render	cility and develop a libilities, ering				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		396021		A. BLDG: _ B. WING: _	00	05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0698	Continued from page 63			F 0698			
SS=D	including but not limite implementation of a re the provision of dialys. A nursing note for Res 2023, indicated that the facility with a right subcentral vein from the a internal jugular vein undressing that was dry a Resident 77, dated Matthe resident had a right site with a dressing in Resident 77, dated Matthe resident was at dial administered upon return Interview with Resident 12:04 a.m. revealed the May 22, 2023; she recoport on her chest; and sidialysis access site) on been accessed.	sident's care plan relais services. ident 77, dated May e resident was admit oclavian catheter (a civillary vein that join nder the clavicle) wind intact. A nursing y 21, 2023, indicated chest double lument place. A nursing not y 19, 2023, indicated ysis and medication arm. at 77 on May 23, 2023, at she went to dialysterved dialysis through the sa a fistula (sur	18, ted to the deep s the th a g note for d that dialysis te for d that would be 23, at is on the the gical				

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	PROVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:		IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021			<u>w</u>	05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	RIVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0698	Continued from page 64			F 0698			
SS=D							
	There was no documer						
	-						
	obtained for hemodialy						
	the access sites.		Č				
	Interview with the Dire	ector of Nursing on I	May 23,				
	2023, at 1:34 p.m. con						
	-	-	1 //88				
	documented evidence		were				
	being monitored.						
	28 Pa. Code 211.12(d)(1)(3)(5) Nursing service						
F 0773				F 0773			
SS=D							
	monitored the dialysis documented evidence to obtained for hemodialy the access sites. Interview with the Direct 2023, at 1:34 p.m. condocumented evidence to dialysis services or for dialysis access sites we documented evidence to being monitored.	site, and there was nothat physician's order ysis services or for meter of Nursing on I firmed that there was that physician's order monitoring Resident ere obtained, and nothat the dialysis sites	May 23, s no rs for t 77's s	F 0773			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER					(X3) DATE SURV COMPLETED:	EY	
		396021				05/24/2023	
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIEN MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE	
F 0773	Continued from page 65			F 0773			
SS=D	483.50(a)(2)(i)(ii) Lab Srvc Results §483.50(a)(2) The facility n (i) Provide or obtain laborat by a physician; physician as clinical nurse specialist in a including scope of practice (ii) Promptly notify the orde assistant, nurse practitioner, laboratory results that fall o ranges in accordance with fa for notification of a practitic physician's orders. This REQUIREMENT is no	nust- ory services only when sistant; nurse practitione ccordance with State law laws. ering physician, physicia or clinical nurse specia utside of clinical referen acility policies and proce oner or per the ordering	ordered er or v, an list of		1) Resident 83 had no adveffects from being straight catheterized to obtain urine specimen without a physicia 2) A sweep will be conducted going back 7 days to ensure residents who were straight catheterized had a physician do so. Identified issues will be corrected at time of discover 3) Licensed nurses were re-educated on the need to he physician orders for invasive procedures such as straight catheterizations. New staff a agency staff will also receive education. The nurse conducted the physician orders obtained for urinary catheterizations. Identifications will be addressed at the of discovery. 4) The Director of Nursing designee will conduct an autorders for urine cultures were weeks and then monthly x 2 to ensure orders were recieved straight catheterization was a Concerns will be addressed to	order. cted other order to be cy. ave e and new e this cting the here were or any ntified he time g or dit of ckly x 4 months ed if required.	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER				PLE CONSTRUCTION: 00	(X3) DATE SURVE COMPLETED:	(X3) DATE SURVEY COMPLETED:	
		396021		B. WING:		05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE		
F 0773 SS=D	Continued from page 66			F 0773	discovery. 5) Audit results will be repthe Quality Assurance Performance Improvement committee to it trends and further opportunit quality improvement and negational education.	rmance dentify ties for	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 396021			(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 05/24/2023	EY
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEAD STATE LICENSE NUMBER: 073202	LTH CARE CTR	STREET ADDRESS, 6 GARDEN CI GREENSBUR	ENTER DR	IVE		
PREFIX MUST BE PREG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEI MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
interviews, it was of to obtain a physicial procedure to collect for one of 41 reside. Findings include: An admission nurs April 29, 2023, revenue confused with a dial and was continent. A nursing note for revealed that the resident that the resident hallucinations. Staturinate so that it contains the resident did not catheterized (an interview of the reside	f clinical records, as well determined that the facilian's order for an invasive a specimen for a labor ents reviewed (Resident ealed that the resident value and bladder. Resident 83, dated May esident's daughter report ent was having increased ff were waiting for the resident 83 was vasive procedure in whitted into the bladder) to	ity failed e atory test 83). 6, dated vas mentia 6, 4, 2023, ed to d resident to ing, but straight ch a	F 0773			

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l i		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		396021			00	05/24/2023	
REDSTON	REDSTONE HIGHLANDS HEALTH CARE CTR 6 GARDE			CITY, STATE, Z ENTER DR G, PA 1560	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0773	Continued from page 68			F 0773			
SS=D	There was no documer record to indicate that a order to collect Resider catheterization. Interview with the Dire May 24, 2023, at 8:50 was no evidence that a obtained for Resident 8 in order to obtain the utage 28 Pa. Code 211.12(d)	ector of Health Navi a.m. confirmed that physician's order was 33 to be straight cath rine specimen.	gation on there as				
F 0812 SS=E				F 0812			

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PLAN OF CORRECTION (POC) (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER			A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/24/2023	
	396021		B. WING.		05/24/2025	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202		STREET ADDRESS, 6 GARDEN CI GREENSBUR	ENTER DR	IVE		
	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
F 0812 Continued from pag SS=E	e 69		F 0812			
483.60(i)(1)(2) Food Procurement, Store/P §483.60(i) Food safe The facility must - §483.60(i)(1) - Procuconsidered satisfactor authorities. (i) This may include producers, subject to regulations. (ii) This provision do from using produce compliance with approactices. (iii) This provision do consuming foods not safety.	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from I producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-hand practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food accordance with professional standards for food service			1) Food Service Manager designee removed and discar chocolate milk, salad, tender hard salami, vegetable blend dry storage that was cited on 2) Food Service Manager designee did a sweep of the late to ensure proper food storage ensure no unlabeled and und food; and to ensure no expire products were present. 3) General Manager and / designee educated the dietary on proper food storage and rathe food labeling and dating with the dietary department. Service Manager and/or desi will conduct food labeling and dating audits daily x2 weeks then weekly x2 months to encompliance. 4) Food Service Manager designee will conduct storage daily x2 weeks and then weemonths to ensure compliance Identified items will be addressed in the salary will be reptite Quality Assurance Performance Pe	rded the rloin, ls, and ls, and ls, and ls, and ls 5/21/23 and/or kitchen le; to lated led or ls staff leviewed policy Food lignee lnd ls and ls sure land/or ls eaudits ls lkly x2 le. lessed lported to	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		396021				05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN CI GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE IDENTI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0812	Continued from page 70			F 0812			
SS=E					Improvement committee to i trends and further opportunit quality improvement and need additional education.	ies for	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 396021			(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 05/24/2023	EY	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN C. GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0812 SS=E	Based on review of po and staff interviews, it facility failed to ensure in accordance with pro- service safety in the wa coolers, and the dry sto Findings include: The facility's policy re- food, dated March 13, foods were labeled wit prepared and opened d The facility's policy re- March 13, 2023, revea storage would be at lea Staff are to cover, labe and opened packages. "sell by," "best by," or discarded. Raw foods separated with cooked raw foods.	was determined that a that food items were fessional standards for alk-in freezer, walk-in	dating all lated, dated ed in dry che floor. ortions by,"	F 0812			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLI IDENTIFICATION NUM:				(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 05/24/2023	EY
NAME OF PROV	VIDER OR SUPPLIER:	370021	STREET ADDRESS,	CITY STATE 7	VIP CODE:	<u> </u>	
	E HIGHLANDS HEALTH	CARE CTR	6 GARDEN C	ENTER DR	RIVE		
STATE LICENS	E NUMBER: 073202		GREENSBUR	.G, PA 1560)1		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
F 0812	Continued from page 72			F 0812			
SS=E							
55 2	Observations in Walk-	May 21,					
	2023, at 9:44 a.m. reve	undated					
	quart of chocolate milk	•					
	18, 2023. Observation	•					
	on May 21, 2023, at 9:						
	staff-prepared ambrosi	•					
	large pan of raw beef to						
	opened and undated pa Observations in the wa	•					
	2023, at 9:52 a.m. reve	-	•				
	undated bag of frozen	•					
	a 20-pound box of mix						
	and exposed to air and	•	•				
	the dry storage area on	May 21, 2023, at 9:	54 a.m.				
	revealed a box of Frito	Lay individual smar	rt				
	popcorn bags and a box	x of snack pack pude	ding				
	stored directly on the f						
	Interview with the Die	tary Manager on Ma	v 21				
	2023, during the tour of		•				
	confirmed that expired	•	•				
	prepared foods should		-				
	meats; all food package	es should be labeled	, dated,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		396021				05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN CI GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0812	Continued from page 73			F 0812			
SS=E	and sealed after openin stored above the floor. 28 Pa. Code 211.6(f) D		ould be				
F 0867				F 0867			
SS=E							

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/ PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			• · · · · · · · · · · · · · · · · · · ·		PLE CONSTRUCTION:	LE CONSTRUCTION: (X3) DATE SURVI COMPLETED:		
				A. BLDG: _				
		396021		B. WING: _		05/24/2023		
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE: 6 GARDEN CENTER DRIVE GREENSBURG, PA 15601					
(X4) ID PREFIX TAG	MUST BE PRECEED!	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
F 0867	Continued from page 74			F 0867				
SS=E								
	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvemen Activities		nt		The Quality Assurance Performance Improvement		Completion Date: 06/19/2023	
	§483.75(c) Program feedback A facility must establish and procedures for feedback, da monitoring, including adver policies and procedures must following: §483.75(c)(1) Facility main obtain and use of feedback and residents, and residents, and residents, and residents.	icies and nd e a, the		Committee will evaluate effectiveness of plan of correction interventions through data review, trend identification and root cause analysis, with emphasis on repeat concerns. 2) Residents who reside in the facility have the potential to be affected by the deficient practice.		Status: APPROVED Date: 06/13/2023		
	including how such information problems that are high risk, and opportunities for impro	ntion will be used to ider high volume, or probler vement.	m-prone,		3) The facility will implen measures to prevent this praction recurring, including:a. Administrator, and Direction Nursing were re-educated research	ector of garding		
	§483.75(c)(2) Facility maintenance of effective systidentify, collect, and use data and information from departments, including but not limited to the facility assessment required at §483.70(e) and including ho information will be used to develop and monitor performance indicators.		all w such		the requirements of the Qual Assurance Performance Improvement Process. b. Quarterly agenda items Quality Assurance Performa Improvement c. Committee will include	for the nce		
	§483.75(c)(3) Facility develoration of performance is methodology and frequency monitoring, and evaluation.			that are high risk, high volum problem prone, as well as question care outcomes, grievance/contrends, resident council feedly prior survey issues and observations from other facility	nality of ncern back,			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER				IPLE CONSTRUCTION: (X3) DATE SU COMPLETED:		EY	
		396021				05/24/2023	
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0867	Continued from page 75		F 0867				
SS=E	the methods by which the facility will systematically identify, report, track, investigate, analyze and use data information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing thos actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determin underlying causes of problems impacting larger system (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of in performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities.		data and c, cop date at those to d. ent rmine tems; ill be event nd of its		committees. 4) The administrator or de will monitor corrective actio ensure effectiveness of these actions including: a. The results of the audits plan of correction monitoring presented in the Quality Assi Performance Improvement A quarterly. b. To prevent the occurrer repeat concerns, the Quality Assurance Performance Improvement Committee will maintain a three year survey calendar to review previous deficiencies and review for compliance. 5) The Administrator or de will oversee the compliance Plan of Correction.	ns to s of the g will be urance Meeting nce of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER					PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		396021				05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0867	Continued from page 76			F 0867			
SS=E	areas; and affect health outcautonomy, resident choice, a \$483.75(e)(2) Performance track medical errors and adotheir causes, and implement mechanisms that include feet the facility. \$483.75(e)(3) As part of the activities, the facility must of improvement projects. The improvement projects conduct the scope and complexity of available resources, as reflect required at \$483.70(e). Impat least annually a project the problem-prone areas identified analysis described in passection. \$483.75(g) Quality assessm \$483.75(g)(2) The quality a committee reports to the face	incidence, prevalence, and severity of problems in the areas; and affect health outcomes, resident safety, residuationomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities me track medical errors and adverse resident events, analytheir causes, and implement preventive actions and mechanisms that include feedback and learning through the facility. §483.75(e)(3) As part of their performance improvem activities, the facility must conduct distinct performar improvement projects. The number and frequency of improvement projects conducted by the facility must the scope and complexity of the facility's services and available resources, as reflected in the facility assessm required at §483.70(e). Improvement projects must in at least annually a project that focuses on high risk or problem-prone areas identified through the data collect and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			COMPLETED:		(X3) DATE SURVE COMPLETED:	EY	
		396021		B. WING: _		05/24/2023	
REDSTON	VIDER OR SUPPLIER: E HIGHLANDS HEALTH E NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN CI GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0867 SS=E	Continued from page 77			F 0867			
	(ii) Develop and implement correct identified quality de (iii) Regularly review and a collected under the QAPI produced the collected under the QAPI produced regimen reviews, and a improvements. This REQUIREMENT is not the collected that the collected regimen reviews are the collected to the collected regimen reviews.	ficiencies; nalyze data, including da rogram and data resultin act on available data to r	ata g from				
F 0887 SS=D				F 0887			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	BER: A. BLDG:		IPLE CONSTRUCTION: (X3) DATE SU COMPLETED:		D:	
		396021		B. WING: _		05/24/2023		
REDSTO	OVIDER OR SUPPLIER: NE HIGHLANDS HEALTI NSE NUMBER: 073202	H CARE CTR	STREET ADDRESS 6 GARDEN C GREENSBUI	CENTER DR	IVE			
(X4) ID PREFIX TAG	MUST BE PRECEEI	NT OF DEFICIENCIES (EACH DE DED BY FULL REGULATORY OF TIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0887	Continued from page 78			F 0887				
SS=D	\$483.80(d)(3)(i)-(vii) COVID-19 must develop and impleme ensure all the following: (i) When COVID-19 vacci resident and staff member is offered the COVID-19 vaccined that already been immunized in Before offering COVID provided with education regarding the benefits and associated with the vaccined (iii) Before offering COVIT resident representative receives education regarding the benefits and associated with the vaccined (iii) Before offering COVIT resident representative receives education regarding the benefits associated with the vaccined potential side effects associated vaccine; (iv) In situations where COMMULTIPLE doses, the resident representative, or current information regarding any changes in the side effects associated with side effects associated	Dimmunizations. The LTC ent policies and procedure ine is available to the facility vaccine unless the immunitor the resident or staff meted; D-19 vaccine, all staff metrics and potential side effect; ID-19 vaccine, each resident of the benefits and risks active with the COVID-19 vaccination requit, staff member is provided ling those additional doses the benefits or risks and potentials and potentials are staff member is provided ling those additional doses the benefits or risks and potentials.	es to lity, each ization is ember embers are effects ent or the and o uires with s, otential		1) Residents 71 and 80 no reside in facility. Resident 6 representative will be educathe risks versus benefits of the COVID-19 vaccine. This had documented in the medical respectatives who refused COVID-19 vaccination will educated on the risks versus benefits of the COVID-19 vand this will be documented medical record. 3) License nursing staff were-educated on the requirem offer the COVID-19 vaccine provide education about the COVID-19 vaccine including risks versus benefits. New so new agency staff will also rethis education. Educational will be provided upon admissabout the COVID-19 vaccine their risks versus benefits. The covidence of the	ted on the as been record. The the be accine I in the will be tent to be and the taff and beceive material ssion are and	Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023	
	requesting consent for adn doses; (v) The resident, resident r has the opportunity to acceptance and change their consensus to the consensus their consensus to the consensus to	ninistration of any additio representative, or staff me ept or refuse a COVID-19	ember		be documented in the medic records. This will be tracked of the admission checklist to completion. 4) The Director of Nursin	d as a part o ensure		

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 396021		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 05/24/2023	
REDSTON	OVIDER OR SUPPLIER: NE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	F OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O IFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE	
F 0887 SS=D	Continued from page 79 (vi) The resident's medical that indicates, at a minimum the following: (A) That the resident or resiprovided education regarding benefits and potential risks vaccine; and (B) Each dose of COVID-1 resident; or (C) If the resident did not reduce to medical contraindications or refusal (vii) The facility maintains COVID-19 vaccination that includes at a minimum, the (A) That staff were provide benefits and potential risks associated with COVID-19 (B) Staff were offered the Con obtaining COVID-19 vaccine information as indicated by and Prevention's National Foundation (NHSN). This REQUIREMENT is not	ident representative was ng the associated with COVID-19 vaccine administered to eceive the COVID-19 vaccine; and documentation related to to following: d education regarding the vaccine; COVID-19 vaccine or infeccine; and e status of staff and relate the Centers for Disease Healthcare Safety Networks	to the accine staff formation ed Control	F 0887	designee will conduct an aud COVID-19 vaccine refusals education was provided and documented weekly x 4 wee then monthly x 2 months to orders were recieved if straig catheterization was required Concerns will be addressed discovery. 5) Audit results will be repethe Quality Assurance Perform Improvement committee to it trends and further opportunit quality improvement and negational education.	to ensure eks and ensure ght upon ported to rmance identify ties for	

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7		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	BER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		396021		B. WING: _		05/24/2023		
REDSTON	VIDER OR SUPPLIER: IE HIGHLANDS HEALTH EE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	AIVE			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
F 0887	Continued from page 80			F 0887				
SS=D								
	Based on clinical recor	rd review, review of	select					
	facility policies and pro		•					
	it was determined that the facility failed							
	provide education regarding the benefits, potential side effects of the COVID-19 va							
	three of five residents i							
	(Residents 60, 71, 80).		izations					
	(Residents 60, 71, 60).							
	Findings include:							
	Review of the policy re	egarding Infection						
	Control-Vaccination for	or COVID-19, dated	March					
	13, 2023, indicates that	t the facility will edu	ıcate					
	residents on the risks a	nd benefits of the Co	OVID					
	vaccines, offer to admi		-					
	vaccination data to Cer							
	(CDC) National Health	2						
	will be collected upon		ine if a					
	resident has been fully	_						
	COVID-19. COVID-1		non					
	handwashing education admission. If applicab		-					
	admission. If applicat	TE THE COVID-19 Va	icenic oi					
				l				

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER, PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		396021		B. WING: _		05/24/2023	
REDSTON	NVIDER OR SUPPLIER: NE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	STREET ADDRESS, 6 GARDEN C GREENSBUR	ENTER DR	IVE		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
F 0887	Continued from page 81			F 0887			
SS=D	booster will be offered physician order for the will complete the Vaccinformed Consent for Vacre Facility form and who will keep a log of vaccine. The vaccine vaccine. The vaccine vaccine of the clinical self-was admitted to the A review of the resider done on admission reversiously refused the 24, 2023, there was not the resident was offerer risks and benefits of the COVID vaccination. Review of the clinical self-was admitted to the review of the resident's	applicable vaccine; sine Administration in Vaccination in Long send it to the identification residents requesting will be ordered on Mass, and administered or record revealed that facility on January in the COVID tracker is ealed that the resident COVID vaccine. A documented evident deducation regarding e COVID vaccine or record revealed that facility on May 19,	nursing Record Term fied staff the Ionday, on Resident 9, 2022. record nt had s of May ce that ng the r the Resident 2023. A				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIE IDENTIFICATION NUMBER				A. BLDG: _00_		COMPLETED:		
		396021		B. WING: _		05/24/2023		
REDSTON	VIDER OR SUPPLIER: NE HIGHLANDS HEALTH SE NUMBER: 073202	CARE CTR	6 GARDEN C	ENTER DR	IVE			
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
F 0887	Continued from page 82			F 0887				
SS=D	done on admission rev previously refused the 24, 2023, there was no the resident was offerer risks and benefits of the COVID vaccination. Review of the clinical 80 was admitted to the review of the resident's done on admission rev previously refused the 24, 2023, there was not the resident was offerer risks and benefits of the COVID vaccination. Interview with the Direct 2023, at 4:15 p.m. condocumented evidence were offered education benefits of the COVID vaccination.	COVID vaccine. A documented evidented education regarding the COVID vaccine of the COVID tracker receased that the resident COVID vaccine. A documented evidented education regarding the COVID vaccine of the COVID vaccin	s of May ce that ng the r the Resident 2023. A ord nt had s of May ce that ng the r the May 24, s no l and 80 and					

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PRINTED: 7/11/2023 FORM APPROVED 2567-L

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER. 396021			A. BLDG:00			ΞY	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202		STREET ADDRESS, 6 GARDEN CI GREENSBUR	ENTER DR	IVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
F 0887	Continued from page 83			F 0887			
SS=D							
	28 Pa. Code 211.12(d)(1)(3)(5) Nursing service						

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
396021				B. WING:		05/24/2023	
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, CITY, STATE, ZIP CODE: 6 GARDEN CENTER DRIVE GREENSBURG, PA 15601				
(X4) ID PREFIX TAG	MUST BE PRECEEDI		ID PREFIX TAG	CORRECTIVE ACTION SH	(X5) COMPLETE DATE		
P 0525	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICUATION) § 201.18(f) Management. (f) A written record shall be maintained on a curr basis for each resident with written receipts for person possessions and funds received or deposited with the facility and for expenditures and disbursements made behalf of the resident. The record shall be available freview by the resident or resident's responsible person upon request. This REGULATION is not met as evidenced by:		onal e de on for on	P 0525	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE 1) Resident 75 will have their personal belongings inventory updated. The process has been initiated for facility to replace the missing hearing aids. 2) A sweep was conducted to complete inventory sheets for other residents. 3) Nursing staff were re-educated on the need to complete and maintain accurate inventory sheets for residents. New staff and new agency staff will also receive this education. Inventory sheet monitoring will be added to the admission check list to ensure it is not missed. 4) The Director of Nursing or designee will conduct an audit of admission audits on 5 residents weekly x 4 weeks and then monthly x 2 months to completion. Concerns will be addressed upon discovery. 5) Audit results will be reported to the Quality Assurance Performance Improvement committee to identify trends and further opportunities for quality improvement and needs for additional education.		Completion Date: 06/19/2023 Status: APPROVED Date: 06/13/2023
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396021		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/24/2023		
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, CITY, STATE, ZIP CODE: 6 GARDEN CENTER DRIVE GREENSBURG, PA 15601					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE			
P 0525	Based on clinical record reviews and staff interviews, it was determined that the facil to maintain a complete and accurate record residents' personal possessions on admission during the residents' stay for one of 41 resi reviewed (Resident 75). Findings include: An interview with Resident 75 on May 21, 1:01 p.m. revealed that while she was bein in bed her hearing aides fell out and she has them since. Review of the clinical record for Resident revealed that she was admitted to the facility May 8, 2023. There was no documented e to indicate that an inventory of personal perform was completed on admission. Interview with the Nursing Home Administy May 25, 2023, at 10:32 a.m. confirmed that		2023, at g assisted s not had 75 ty on vidence ssessions	P 0525				

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Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 396021			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 05/24/2023		
NAME OF PROVIDER OR SUPPLIER: REDSTONE HIGHLANDS HEALTH CARE CTR STATE LICENSE NUMBER: 073202			STREET ADDRESS, CITY, STATE, ZIP CODE: 6 GARDEN CENTER DRIVE GREENSBURG, PA 15601				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
P 0525	facility was unable to find the inventory sheet for Resident 75. Her son reported the missing hearing aides to the receptionist and the process has been transferred to the concern log for investigation.		P 0525				

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Certified End Page

REDSTONE HIGHLANDS HEALTH CARE CTR

STATE LICENSE NUMBER: 073202 SURVEY EXIT DATE: 05/24/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY